## MEDICATION ADMINISTRATION FORM

Department of Health & Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
6 St. Paul Street, Suite 1301
Baltimore, Maryland 21202-1608
(410) 767-8417 FAX (410) 333-8926
Toll Free 1-877-4MD-DHMH ext. 8417

I. FACILITY RECEIPT AND REVIEW													
MEDICATION RECEIVED FROM										DATE			
PLAN OF ACTION RECEIVED [ ]				ES []N	0	[ ] N/A	HEALTH	SUPER\	ISOR NOT	IFIED	[]YES	[ ] NO	
MEDICATION RECEIVED BY				SON'S SIGNA		D		DATE					
II. MEDICATION ADMINISTRATION RE													
separate m	Each administration of the listed medication shall be noted on the child's record below. Each nonprescription and prescription medication requires a separate medication authorization form and the administration of the listed medication is required to be recorded on the corresponding administration record.												
Child's Na			Date of Birth:										
Medication													
Route:	i Naille.				Dosage: Time(s) to Admin					etor:			
DATE	REACTION OBSERVED (IF ANY)				ummstei	SIGNATURE							
DATE	TIME	DOSAG	,_	REACTION OBSERVE			ED (IF ANT)			SIGNA	TORE		
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